

Please include all children living at home, even if you are not applying for that child. If you have more than 6 children, please attach additional pages answering similar series of questions below.

[illegible]

Child's Father's Name

[illegible]

## Section 2: Information About Children (Cont.)

**QUESTIONS—Please check one (Y or N)**

	Child 4	Child 5	Child 6
1. Is this child's address the same as the parent's/adult's? (Each child and pregnant woman must apply from his or her home address).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this child a U.S. citizen? (If No, you must send a copy with your application of the document that indicates this child's legal status in the U.S.).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does this child live in Tennessee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does this child have health insurance? (If Yes, copy the front and back of each insurance card and send it with your application).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. a. Has this child had health insurance that ended in the past 3 months? (If Yes, a written statement must be sent with your application, listing the policy number and insurance company name and explaining why the insurance ended).  b. Date Insurance Ended:	<input type="checkbox"/> Yes <input type="checkbox"/> No  <div>MM/DD/YYYY</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <div>MM/DD/YYYY</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <div>MM/DD/YYYY</div>
6. Does this child have Children's Special Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. We want to make sure that your child is considered for all coverage that may be right for them. Please answer the following questions:  a. Does this child have a diagnosed medical condition (including pregnancy) or disability? (If the child is pregnant, please fill out the HealthyTNBabies Questions).  b. If Yes, what is the name of the condition or disability?  c. Have you been denied for Supplemental Security Income (SSI) for this child?	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>                                </div> <div>                                </div> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>                                </div> <div>                                </div> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>                                </div> <div>                                </div> <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does this child have a parent that works for State or local government?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. a. Do you receive child support for this child?  b. If Yes, what amount do you receive per month per child?	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>       .</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>       .</div>	<input type="checkbox"/> Yes <input type="checkbox"/> No <div>       .</div>
10. a. Does this child have TennCare or TennCare Standard?  b. If Yes, which one?  c. Date TennCare Ended  d. Have you filed an appeal or plan to file an appeal?	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> TennCare <input type="checkbox"/> TennCare Standard  <div>MM/DD/YYYY</div> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> TennCare <input type="checkbox"/> TennCare Standard  <div>MM/DD/YYYY</div> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> TennCare <input type="checkbox"/> TennCare Standard  <div>MM/DD/YYYY</div> <input type="checkbox"/> Yes <input type="checkbox"/> No

If you need help with your application, call 1.866.620.8864 (This is a free call.)

◆ Fax 1-866-913-1046 ◆ TTY 1-866-447-0272 (These are free calls.)

Language interpreter services are available in many languages including Spanish.

Si Ud. necesita ayuda con la aplicacion, llámenos. La llamada es gratis

Hours: Monday through Friday 7 AM to 6 PM (Central Standard Time)